Supreme Court, U.S.
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No. 01-827

In The

Supreme Court of the United States

CRYSTAL STAR PHILLIPS, Individually, and As next of kin to Martin Shane Phillips, on behalf of THE ESTATE OF MARTIN SHANE PHILLIPS By and through her mother, legal guardian and Next friend, MINNIE CHRISTINA DACZEWITZ, and FRED MARTIN PHILLIPS, JR., parent of Martin Shane Phillips,

Petitioners,

versus

HILLCREST MEDICAL CENTER, an Oklahoma Corporation doing business in the State of Oklahoma,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

BRIEF IN OPPOSITION FOR RESPONDENT HILLCREST MEDICAL CENTER

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QUESTIONS PRESENTED

1. Whether the Tenth Circuit's decision regarding the appropriate medical screening required by EMTALA properly affirmed the standards previously set forth by the Tenth Circuit and other Circuit Courts of Appeals?

2. Whether the Tenth Circuit was correct in its determination that EMTALA does not replace pre-existing state medical negligence laws?

PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT

In addition to the parties listed by the Petitioners, Carolyn Cobb, M.D., and Emergency Physicians, Inc. (later amended to Tulsa Emergency Physicians, Inc.) were parties in the proceedings before the district court. No appeal was filed in regard to the jury verdict and judgment in favor of Dr. Cobb and Tulsa Emergency Physicians, Inc.

Respondent Hillcrest Medical Center's parent corporation is Hillcrest Healthcare Systems. No publicly held company owns 10% or more of the stock of Hillcrest Medical Center.

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STATEMENT OF THE CASE

A. Introduction

Petitioners/Plaintiffs (Crystal Star Phillips, daughter of the deceased Martin Phillips, and Fred Phillips, father of Martin Phillips, hereinafter referred to as "Plaintiffs") initiated this litigation on October 23, 1998 against Defendants Hillcrest Medical Center (hereinafter "HMC"), Carolyn Cobb, M.D. (hereinafter "Dr. Cobb"), and Emergency Physicians, Inc. (later amended to Tulsa Emergency Physicians, Inc., hereinafter "TEP"). The deceased, Martin Phillips (age 25), presented to the emergency room at HMC on September 23, 1998, and was evaluated, diagnosed, and treated there before being discharged the same day by Dr. Cobb. Five (5) days later, Phillips was taken to the emergency room at Tulsa Regional Medical Center (hereinafter "TRMC") and died. The cause of death was listed as acute bacterial endocarditis, which is an infection/inflammation of the lining of the heart.

Plaintiffs' lawsuit against HMC, Dr. Cobb, and TEP was founded upon two causes of action: (1) violation of the screening requirement found at 42 U.S.C.A. § 1395dd(a), the Emergency Medical Treatment and Active Labor Act (known as EMTALA); and (2) Oklahoma state law claims of medical malpractice, common law negligence, and wrongful death for the Defendants' failure to properly diagnose, evaluate and treat Phillips. The Court dismissed Plaintiffs' EMTALA claims against Dr. Cobb and TEP prior to trial.

A jury trial commenced on December 13, 1999, before the Honorable Sven Erik Holmes, District Judge for the

Northen District of Oklahoma, and concluded on December 18, 1999. Prior to submitting the case to the jury, Judge Holmes sustained the Rule 50 motion by HMC, finding that no EMTALA claim existed as a matter of law (Tr., 12/16/99, Vol. II, p. 851); sustained Rule 50 motions by all Defendants on the issue of punitive damages, (Tr., 12/16/99, Vol. II, p. 1019); sustained Plaintiffs' Rule 50 motion, finding that Dr. Cobb was an ostensible agent of Hillcrest. (Tr., 12/16/99, Vol. II, p. 1023).

The case was then submitted to the jury on the state law claims of medical malpractice, common law negligence, and wrongful death. The jury found no negligence by any Defendant and returned verdicts in favor of HMC, Dr. Cobb, and TEP. Judgment was entered for each Defendant accordingly.

On January 21, 2000, Plaintiffs filed their Notice of Appeal to the Tenth Circuit Court of Appeals as to HMC only. No appeal was filed in regard to the jury verdict and judgment in favor of Dr. Cobb and TEP. On appeal to the Tenth Circuit, Plaintiffs alleged that the District Court erred in sustaining HMC's Rule 50 motion regarding EMTALA; that the District Court erred in admitting evidence regarding Martin Phillips' prior drug use; that Plaintiffs should have been allowed to introduce testimony regarding the cause of Phillips' bacterial endocarditis; and that the District Court limited the scope of Plaintiffs' questions regarding Exhibits 25 and 26 (redacted and retyped versions of emergency room log records).

The United States Court of Appeals for the Tenth Circuit affirmed the judgment in favor of HMC, holding

that a hospital's treatment of a patient regarding a perceived lack of insurance was irrelevant to a claim under EMTALA; that HMC did not violate the medical screening requirements of EMTALA; that, pursuant to Oklahoma law, a patient's failure to disclose drug use was relevant to HMC's contributory negligence defense; that the exclusion of expert testimony regarding the cause of bacterial endocarditis was not an abuse of discretion; and, that the exclusion of certain exhibits was not an abuse of discretion by the District Court.

B. Statement of Facts

Respondent/Defendant HMC is mindful of Rule 15.2's admonition that a brief in opposition "should be stated briefly." Rule 15.2 also states that the brief in opposition "should address any perceived misstatement of fact or law." HMC submits that the Statement of the Case presented by the Petitioners in their Petition is lengthy, incomplete, argumentative, and, at times, misstates the evidence presented. Therefore, HMC presents this more accurate statement of facts for the benefit of this Honorable Court.

On September 23, 1998 at 1:25 p.m., Martin Phillips (hereinafter "Phillips"), presented to the HMC emergency room with complaints of neck and chest pain when breathing. The evidence disclosed conflicting versions of his symptoms prior to that time, but generally showed that he was at work without apparent problems on Monday, September 21, did not come to work on Tuesday, September 22, and on Wednesday, September 23, his friend and co-worker Mike Lulka went to his trailer and

decided to take Phillips to the doctor. After first stopping for a soda pop at QuikTrip, they proceeded to Eastside Family Clinic, the physician group for his employer, American Crating. The doctors at Eastside Family Clinic did not work on Wednesday afternoon. Thus, Phillips requested that his friend Mike Lulka take him to Hillcrest Medical Center. En route, Phillips "bummed a cigarette" from Mr. Lulka. (Tr., 12/14/99, Vol. I, p. 220).

Upon arrival at Hillcrest, Phillips was first seen by the triage nurse, Lugenia Cue, R.N. and reported to her complaints of neck and chest pain for two days, respirations regular and unlabored, pain with movement (HMC Medical Chart of Martin Phillips, Pet'r. Supp. App., p. 8). Ms. Cue recorded his vital signs as follows: temperature at 98° respirations at 16, pulse at 112, and blood pressure of 129/55. *Id.* He was not sweating and his chest pains were with movement. (Tr., 12/14/99, Vol. I, pp. 353 and 356).

The emergency room at Hillcrest has two departments: a minor care side and a trauma side, the purpose being to allow those on the minor care side to be seen more quickly, while those perceived to have more serious medical problems are sent to the trauma side. (Tr., 12/14/99, Vol. I, pp. 350-353). The same physicians may work on either the minor care or trauma side of the emergency room. (Tr., 12/14/99, Vol. I, p. 301). Mr. Phillips was triaged as category III and was assigned to see a physician on the minor care side of the emergency room. (Tr., 12/14/99, Vol. I, p. 381).

Phillips was next seen by the registration/processing clerk for demographic and registration information. (Tr.,

12/14/99, Vol. I, p. 321). Mr. Lulka was with him for the registration process. Phillips did not have his insurance card as his employer had recently changed insurance companies. (Tr., 12/14/99, Vol. I, p. 201). Mr. Lulka showed the clerk his insurance card since all employees had the same insurance. The process seemed fairly routine, just getting biographical information, and the fact that Phillips did not have his insurance card, according to Mr. Lulka, "wasn't that big a deal." (Tr., 12/14/99, Vol. I, p. 221). Once the clerk received this information, she accepted it and finished the registration process. (Tr., 12/14/99, Vol. I, p. 222). The note on the Registration Information sheet noted "No card. No payment. Advised Pt. to call the business office with insurance info." (Pet'r. Supp. App., p. 4).

Phillips then waited to be seen by a physician. Mr. Lulka testified that, during that time, Phillips had tears in his eyes, was slumped over, and was in pain. However, his symptoms "kind of changed as we were sitting there. Sometimes he would seem like he was cold." (Tr., 12/14/99, Vol. I, p. 203). Lulka described the chest pain Phillips had in the waiting room as hurting when he took a deep breath. (Tr., 12/14/99, Vol. I, p. 224).

At 2:15 p.m., Phillips was taken back to an examination room and initially seen by a nurse, Barbara Petty, L.P.N. Ms. Petty took a brief history from Phillips, reporting "Patient states that it hurts to breath in and out since yesterday. Has a stiff neck x 3 weeks, a headache for three weeks with neck pain," and smokes one pack of cigarettes per day. (HMC Medical Chart of Martin Phillips, Pet'r. Supp. App., p. 6; Tr., 12/14/99, Vol. I, p. 388).

Phillips was then seen and evaluated by Dr. Cobb, an emergency room physician employed by TEP. (TEP had a contract with HMC to provide physicians services in the emergency room). Dr. Cobb testified that upon entering the exam room, Phillips was sitting quietly on the examination table. She shook his hand. He did not appear to be in distress. He was not moving restlessly. He was not sweating. He made good eye contact. She asked Phillips what he was there for and he indicated that he had come in because his neck was very sore, it was sore to turn his head from side to side, and he had some episodes of chest pain when he breathed in and out. (Tr., 12/14/99, Vol. I, p. 286). Dr. Cobb did a thorough examination, looking at his eyes, his ears, his mouth, listening to his lungs, and heart. (Tr., 12/14/99, Vol. I, pp. 286-290, 292, 293). She found his heart rate to be regular with no murmur. (Tr., 12/14/99, Vol. I, p. 294). Phillips denied chills, nausea or vomiting. (HMC Medical Chart of Martin Phillips, Pet'r. Supp. App., p. 12).

In addition to the personal examination, Dr. Cobb reviewed the history of Phillips, including the "Review of Systems" form, which included a "Social History/Personal Habits" section, which had been answered by Phillips. (HMC Medical Chart of Martin Phillips, Pet'r. Supp. App., p. 10). Dr. Cobb described the patient's history as "very significant", and stated "I have to know his history in order to know how to proceed." (Tr., 12/14/99, Vol. I, p. 297). Dr. Cobb made note of the fact that Phillips indicated he was a cigarette smoker , and that he denied the use of street drugs. Dr. Cobb testified that use of street drugs, cigarettes or alcohol were important risk

factors for various medical problems, and that particularly drug usage potentially suggested many infectious diseases and liver problems for which the normal population was not at risk. She testified that drug usage was a red flag and, had it been answered "yes" by Phillips, it could have changed her evaluation. (Tr., 12/14/99, Vol. I, pp. 297, 298).

Dr. Cobb concluded her evaluation and, contrary to Petitioners' allegation regarding lack of diagnosis by Dr. Cobb, diagnosed Phillips as having paracervical myalgia and pleuritic type chest pain, (pain in the lining of the lungs as opposed to cardiac chest pains), and prescribed a pain medication and an anti-inflammatory.[1] (HMC Medical Chart of Martin Phillips, Pet'r. Supp. App., p. 12). Phillips was discharged from the emergency room at 4:25 p.m. in no apparent distress. Phillips was not "transferred" to the OU Family Practice Clinic, as Petitioners now suggest; rather, per Phillips' Discharge Instructions,

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[1] Petitioners state that Mr. Phillips was never diagnosed at Hillcrest, and that no determination was made whether had an emergency medical condition. This allegation is wholly inaccurate. Mr. Phillips' medical records indicate that he was diagnosed with paracervical myalgia and pleuritic type chest pain, and was given Parafon Forte and an anti-inflammatory. (Pet'r. Supp. App., pp. 12-13). Petitioners' reference to an emergency room log and examination of a witness who had no personal knowledge of Phillips' entry on the log is also misleading, as the witness testified that the "?" under disposition meant that whoever filled out the log did not have a diagnosis to put on the log. (Tr., 12/14/99, Vol. I, p. 337). No witness ever testified that there was no diagnosis; in fact, Dr. Cobb's testimony and the medical record indicate exactly the contrary.

he was to follow-up with the OU Family Practice Clinic, a common referral source for all Tulsa hospitals when the patient either does not have a personal physician or a method of payment. The OU Family Practice Clinic was never characterized by any witness as a "free clinic" – it is not free, there are charges made if the patient is able to pay or has insurance. (Tr., 12/16/99, Vol. II, p. 994).

The day following Phillips' discharge from HMC, (Thursday, September 24, 1998), Phillips continued to be symptomatic. He was seen at work on Thursday, and returned to the workplace on Friday (September 25) to get his paycheck. At that time, one co-worker described his symptoms as much more severe than on Wednesday. (Tr., 12/13/99, Vol. I, p. 93).

On Saturday morning, September 26, Fred Phillips, (Martin Phillips' father), went to the home of Phillips to see how his son was doing. Phillips complained of pain, primarily a headache, and Fred Phillips took his son to a café for brunch where Phillips ate bean soup. (Tr., 12/14/99, Vol. I, p. 441). Phillips complained that his back was hurting and Fred Phillips massaged points along his back. (Tr., 12/14/99, Vol. I, p. 442). When Fred Phillips left several hours later, he did not think that Phillips had an acute illness, but thought it might be bronchitis and a headache. (Tr., 12/14/99, Vol. I, p. 444).

On Sunday, September 27, Christy Wiseman, (sister-in-law of Phillips), who had spoken with Phillips on the telephone, called Fred Phillips and said that Phillips was getting worse. Fred Phillips went to pick up his son and took him to Fred's home. The condition of Phillips was a little worse than on Saturday. He ate dinner and later

went to bed. (Tr., 12/14/99, Vol. I, p. 445). At about three o'clock in the morning, Fred Phillips heard his son crying and was coughing up blood. Fred Phillips decided to take his son to TRMC.[2]

Phillips arrived at TRMC at 5:46 a.m. with a chief complaint of nausea and vomiting for three or four days. Phillips gave a history of a headache for three weeks and a seizure one month previously. Phillips also denied use of street drugs and alcohol. (TRMC Medical Chart of Martin Phillips, Pet'r. Supp. App., p. 41). From the history, the emergency room doctor, Dr. Murta, was able to ascertain that the patient had become progressively worse over the previous twenty-four hours. (Tr., 12/13/99, Vol. I, pp. 115, 116). Phillips denied any chest pain at that time or within the last week, and pain wasn't something Dr. Murta was concerned about. *Id.*, at pp. 118, 119. Dr. Murta had a working diagnosis of pneumonia, heart failure and infection. *Id.*, at p. 111.

Dr. Murta went off duty and he was relieved by Dr. Stan Stacy, another emergency room physician. Dr. Stacy became concerned that they were dealing with something beyond pneumonia. Fred Phillips reported to Dr. Stacy that he had contacted the place of employment for Phillips and the co-workers confessed that Phillips had a

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[2] Throughout the Petition, Petitioners refer to TRMC as a "sister hospital" of HMC. This is misleading and inaccurate, as discovery disclosed that in September 1998, there was no relationship between TRMC and HMC. At that time, TRMC was owned and operated by Columbia/HCA. Subsequent to this incident, on January 1, 1999, TRMC did become part of the Hillcrest Healthcare System.

history of methamphetamine abuse. (TRMC Medical Chart of Martin Phillips, Pet'r. Supp. App., p. 44). Dr. Stacy ordered an echocardiogram and confirmed bacterial endocarditis. Mr. Phillips' condition continued to deteriorate and he was pronounced dead at 9:22 a.m. The cause of death was listed as acute bacterial endocarditis. (Certificate of Death, Pet'r. Supp. App., p. 20).

REASONS FOR DENYING THE PETITION FOR WRIT OF CERTIORARI

SUMMARY OF THE ARGUMENT

Petitioners have only requested that this Court review the portion of the Tenth Circuit's decision regarding the standard affirmed by the Tenth Circuit relating to the medical screening requirement of EMTALA. HMC respectfully submits that Petitioners' request for review of the Tenth Circuit decision regarding EMTALA is without merit. The Tenth Circuit correctly found that HMC did not violate the medical screening requirements of EMTALA, found at 42 U.S.C.A. § 1395dd(a). The Tenth Circuit has not adopted a "new" standard, as Petitioners suggest. Rather, the Tenth Circuit's decision reiterates the standards articulated in existing case law, both in the Tenth Circuit and other Circuits, which interpret the requirements set out by Congress regarding EMTALA.

In the "Statement of the Case" portion of their Petition, Petitioners allege that their lawsuit against HMC involved allegations of "failure to screen" (42 U.S.C.A. § 1395dd(a)) and "failure to stabilize prior to transfer" (42

U.S.C.A. § 1395dd(b)). This reference to "failure to stabilize," found in subsection (b) of the EMTALA statute, is the **first time** Petitioners have **ever** made any allegation that HMC failed to "stabilize" Mr. Phillips. *See Pretrial Order,* App., p. 3, ("Plaintiffs' remaining contentions: . . . 3. Defendant Hillcrest Medical Center failed to provide an appropriate medical screening examination within the capabilities of the emergency department, which constitutes a violation of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. § 1395dd . . . "). *See also Appellants' Opening Brief to the Tenth Circuit,* p. 10 (" . . . Plaintiffs have pursued HMC under EMTALA § 1395dd(a) for intentional discrimination based on Phillips [sic] status of not having insurance. . . . "); *Plaintiff's Opening Statement,* Tr., 12/13/99, Vol. I, p. 28 (" . . . You're going to hear about a federal law. This federal law requires hospitals like Hillcrest to provide an appropriate medical screening to some patients . . . Marty Phillips was never provided an appropriate medical screening at Hillcrest."); *Phillips v. Hillcrest Medical Center,* 244 F.3d 790, 796 (10th Cir. 2001) (finding that Appellants' only claim under EMTALA is for an alleged failure to provide an appropriate screening).

While this "failure to stabilize" argument is not specifically addressed in the "Argument" portion of the Petition, HMC respectfully requests that this Court decline to consider any issues the Petitioners now attempt to raise regarding the "failure to stabilize," as this issue has never been raised prior to this Petition. *Youakim v. Miller,* 425 U.S. 231, 234 (1976) (holding that this Court does not decide questions not raised or involved in the lower court).

I. CIRCUIT COURTS ARE UNIFORM IN THEIR INTERPRETATION OF 42 U.S.C.A. § 1395dd(a).

A. The Tenth Circuit's interpretation and application of EMTALA's medical screening requirement is consistent with the majority of Circuit Courts.

In the instant case, the Tenth Circuit correctly held that the basic principle behind 42 U.S.C.A. § 1395dd(a) ("appropriate screening" requirement) is to ensure all patients, regardless of their perceived ability or inability to pay for medical care, are given consistent medical attention. *Phillips, supra,* at 797. The Tenth Circuit further found that EMTALA requires that HMC apply uniform screening procedures to all individuals coming to the emergency room. *Id.* The Tenth Circuit also held that a hospital's obligation under EMTALA is measured by the extent to which the hospital treats every patient "perceived" to have the same medical condition in the same manner. *Id.* In other words, whether a hospital provided an appropriate medical screening is based on the hospital's *actual knowledge* of the patient's medical condition, and not what the Plaintiff alleges the hospital *should have inferred.*

The Tenth Circuit's standards and interpretation of the EMTALA statute in the instant case regarding medical screening are supported by virtually every Circuit Court of Appeals which has interpreted the medical screening requirement enacted by Congress in the EMTALA statute. The Petitioners attempt to argue that the Circuit Courts are "split" on their interpretation and application of the medical screening requirement of EMTALA. In support of

this position, the Petitioners state that this Court recognized the "split of the circuits" in *Roberts v. Galen*, 525 U.S. 249, 142 L. Ed. 2d 648, 67 USLW 4062 (1999). This is a misstatement of this Court's finding in *Roberts*.

First, in *Roberts*, this Court was considering subsection (b) of § 1395dd, regarding the *stabilization* requirement of EMTALA, which is not at issue in the instant case. Secondly, this Court specifically stated that the subsection (a) "appropriate medical screening" requirement (which *is* at issue in the instant case) was *not* before the Court in *Roberts*, and that the Court declined to express any opinion on subsection (a) of § 1395dd. *Roberts*, at 687. Finally, contrary to the Petitioners' representation in their brief, this Court did not "recogniz[e] a split of the circuits" regarding the interpretation of subsection (a), but simply stated that the Sixth Circuit in *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990), differed from other Circuits in imposing an "improper motive" requirement regarding subsection (a). *Roberts*, n. 1.[3] The majority of the Circuit Courts agree that a finding

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[3] The Sixth Circuit in *Cleland* held that "appropriate" should be interpreted to refer to the "motives" with which the hospital acts. *Cleland*, at 272. Most, if not all, other Circuit Courts of Appeals have declined to also require a showing of "improper motivation" on the part of the hospital before finding that the hospital failed to provide an appropriate medical screening. Interestingly, however, the *Cleland* decision goes on to state that, if the hospital acts in the same manner as it would with a paying patient, then the medical screening is "appropriate." *Id.* This holding is essentially in line with the holdings of other Circuit Courts of Appeals which have held that EMTALA requires hospitals to apply their standard screening procedure uniformly to all patients. *See, e.g., Baber v.*

of improper motive is not required to maintain a claim for failure to provide an "appropriate medical screening."

Regardless of *Cleland*'s "motive" requirement, (and HMC submits "motive" is not at issue in the instant case, as Phillips had insurance and received a medical screening by nursing personnel *and* an emergency room physician), the Circuit Courts of Appeals have uniformly interpreted subsection (a) regarding the medical screening requirement of EMTALA, and have found that EMTALA was not meant to create a federal standard of care regarding emergency room care and treatment. Specifically, EMTALA requires a screening examination to determine whether or not an emergency medical condition exists. 42 U.S.C.A. § 1395dd(a). The *accuracy* of the diagnosis, however is a question for state medical malpractice law, and not EMTALA [emphasis added]. *Vickers v. Nash General Hospital*, 78 F.3d 139, 143 (4th Cir. 1996).

B. Contrary to Petitioners' contention, the Tenth Circuit has not articulated a new "perceived" standard, but has affirmed its own previous holdings and the holdings of other Circuit Courts.

Petitioners complain that the Tenth Circuit has articulated a new standard, in that the Tenth Circuit in the instant case held that a hospital's obligation under EMTALA is measured by the extent to which the hospital treats every patient "perceived" to have the same medical

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Hospital Corporation of America, Inc., 977 F.2d 872, 878 (4th Cir. 1992).

condition in the same manner. *Phillips,* at 797. The Tenth Circuit's holding in *Phillips* regarding what the hospital "perceived" the patient's condition as being is far from "new" standard, and has been articulated multiple times by various courts. *See Repp v. Anadarko Municipal Hospital,* 43 F.3d 519, 522 (10th Cir. 1994) (held that section 1395dd(a) was *not* intended to ensure each emergency room patient received a *correct* diagnosis, but to ensure that each patient is given the same level of treatment regularly provided to patients in similar medical circumstances); *Vickers v. Nash General Hospital,* 78 F.3d 139, 144 (4th Cir. 1996) (holding that EMTALA is implicated only when individuals *perceived* to have the same medical condition are treated disparately; EMTALA is not implicated when individuals *in fact* have the same condition, and receive disparate treatment; Defendant doctor treated plaintiff for what doctor *perceived* to be the plaintiff's medical condition); *Baber v. Hospital Corporation of America,* 977 F.2d 872, 879 (4th Cir. 1992) (holding that EMTALA does not guarantee that the hospital personnel will correctly diagnose a patient's condition as a result of the medical screening; emergency doctor treated plaintiff for what he *perceived* to be the plaintiff's medical condition); *Cunningham v. Fredonia Regional Hospital,* 98 F.3d 1349 (10th Cir. 1996) (unpublished decision, attached hereto, App., pp. 6-12) (hospital did not *perceive* that Plaintiff had potentially life-threatening symptoms); *Tank v. Chronister,* 941 F. Supp. 969, 973 (D. Kan. 1996) (EMTALA requires *actual knowledge* of emergency medical condition).

In the instant case, the Tenth Circuit's decision falls squarely in line with the way previous Circuit Courts of

Appeals have interpreted EMTALA. No new "perceived" standard exists, as Petitioners indicate; rather, the standard articulated in the instant case by the Tenth Circuit is the identical standard set out by the Tenth Circuit and other Circuit Courts of Appeals considering the "medical screening" requirement of EMTALA – to provide the same medical treatment to patients in similar medical circumstances. A hospital can only be charged with what it actually determines (or "perceives") a patient's medical condition to be, not what the patient, in hindsight, asserts that the hospital should have determined. This issue – whether the hospital was correct in its "perception" – is left to the realm of state medical negligence law, and is not governed by EMTALA.[4]

II. POPULATION IS NOT PUT AT RISK BY TENTH CIRCUIT'S DECISION; STATE MEDICAL MALPRACTICE LAW, NOT EMTALA, EXISTS TO PROTECT CITIZENS WHEN AN ERROR IS MADE IN MEDICAL DIAGNOSIS, CARE AND/OR TREATMENT.

The Petitioners allege that the Tenth Circuit's decision in the instant case puts the population at risk, or at least those who seek emergency medical care and treatment. Petitioners argue that a hospital should not be able to submit facts and evidence which show what its personnel "perceived" when providing care and treatment to a

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[4] In the instant case, the issue of whether the Defendants were negligent pursuant to state medical malpractice law went to the jury, and the jury found in favor of the Defendants.

patient who presents to the emergency room for treatment. The Petitioners argue that, because HMC's diagnosis was allegedly incorrect, they incorrectly "perceived" Mr. Phillips' medical condition. (In fact, Petitioners go so far as to boldly suggest that the HMC triage nurse, the HMC treatment nurse, and Dr. Cobb falsified records and misrepresented Mr. Phillips' condition, even though no evidence whatsoever exists to support this novel theory,[5] and even though the findings by these personnel were verified by the Plaintiff's own witness and friend of Mr. Phillips, Mike Lulka.)

Petitioners ignore the principle that accuracy of the diagnosis is a question for state malpractice law, and not EMTALA. As the court stated in *Vickers, supra*, "If disparate treatments based on disparate diagnoses sufficed to raise a claim under EMTALA, every allegation of misdiagnosis could automatically be recast as a claim under [EMTALA]: An improperly diagnosed patient can always assert that a properly diagnosed patient would have

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[5] Allegations of document tampering are scattered throughout Petitioners' Petition for Writ of Certiorari. In addition to an alleged relationship between HMC and TRMC which did not in fact exist, Petitioners also refer to a "blank" triage sheet produced by HMC, and indicates that the "loops" and whited-out marks show that this sheet was allegedly that of Phillips which was later allegedly altered. None of these allegations were ever proven, nor really ever pursued by Petitioners in the trial of this matter. The "blank" triage sheet was produced by HMC when the Petitioners requested a "blank" triage sheet in discovery. HMC no longer used that kind of sheet, and "whited out" a sheet for the Plaintiffs. (Tr., 12/14/99, Vol. I, p. 341). This sheet has absolutely no relation whatsoever to the decedent or his care and treatment of HMC.

received a difference course of treatment." *Vickers v. Nash General Hospital*, 78 F.3d 139, 144 (4th Cir. 1996). *See also Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (quoting court's earlier opinion in related case, held that EMTALA is not a federal malpractice statute and does not set national emergency health care standards; claims of misdiagnosis or inadequate treatment left to state malpractice arena); *Collins v. DePaul Hospital*, 963 F.2d 303, 306-307 (10th Cir. 1992) (subsection (a) requires that a hospital provide appropriate medical screening examination of injured person presenting to the hospital to determine whether emergency condition exists – nothing more, nothing less). EMTALA is a statute with limited application and the Tenth Circuit correctly affirmed the District Court's decision.

III. THE TENTH CIRCUIT'S HOLDING IS CONSISTENT WITH AND SUPPORTS CONGRESS' ORIGINAL INTENT IN ENACTING EMTALA.

Plaintiff alleges that the Tenth Circuit's decision in the instant case departs from the original intent of Congress in enacting EMTALA. As the Petitioners indicate, EMTALA was enacted by Congress to address a growing concern with the prevention of patient "dumping" – the practice of refusing medical treatment to patients unable to pay, or transferring the patient before an emergency condition was stabilized. *Vickers v. Nash General Hospital*, 78 F.3d 139, 142 (4th Cir. 1996). *See also Abercrombie v. Osteopathic Hospital Founders*, 950 F.2d 676, 680 (10th Cir. 1991). EMTALA is limited, however, in its application and purpose. *Ingram v. Muskogee Regional Medical Center*, 235 F.3d 550, 552 (10th Cir. 2000) (holding that EMTALA's

provisions have a limited reach and purpose). The statutory language of EMTALA clearly indicates that no national standard of care is to be imposed regarding the screening of patients. *Baber v. Hospital Corporation of America*, 977 F.2d 872, 879 (4th Cir. 1992). A hospital is only required to provide an appropriate screening examination within the capabilities of the hospital's emergency department. *Id.* Courts will not assume that the purpose of EMTALA was to create a "vast new realm" of federal law which creates a *federal* remedy for injuries which is already addressed by state law [emphasis added]. *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996).

In the instant case, two nurses and an emergency room physician were involved in the evaluation, examination, and treatment of Mr. Phillips. He was diagnosed by the emergency room physician as having paracervical myalgia and pleuritic type chest pain (pain in the lining of the lungs as opposed to cardiac chest pain), and prescribed a pain medication and an anti-inflammatory. The emergency room physician, after her examination and diagnosis, saw no need to admit Mr. Phillips to the hospital, as his condition did not warrant hospital admission. (Tr., 12/14/99, Vol. I, p. 296). Mr. Phillips was discharged, and instructed to follow up with the OU Family Practice Clinic if needed. No evidence exists which disputes these facts.

The evidence presented at trial clearly indicates that Mr. Phillips received an adequate medical screening, and was not "dumped," as Petitioners continue to assert. The

Tenth Circuit, considering this evidence, affirmed the district court's finding that HMC did not violate the screening requirements of EMTALA. *Phillips*, at 799. In making that determination, the Tenth Circuit correctly found that a hospital's obligation under EMTALA is to treat every patient perceived to have the same medical condition in the same manner. *Id.*, at 797. While Petitioners apparently disagree with the "perception" of the medical personnel from HMC who provided care and treatment to Phillips, no evidence exists which indicates that Mr. Phillips was treated differently than any other patient with the same perceived symptoms. The Tenth Circuit's decision in the instant case clearly supports the plain language of EMTALA and Congress' intent in enacting the statute.

IV. THE TENTH CIRCUIT'S DECISION DOES NOT VIOLATE THE SEPARATION OF POWERS DOCTRINE.

Petitioners contend that the Tenth Circuit's decision in the instant case violates the separation of powers doctrine. To the contrary, the Tenth Circuit has interpreted the EMTALA statute exactly as it is charged to do pursuant to the separation of powers doctrine, and has interpreted it in line with other cases within its jurisdiction, as well as in line with courts in other jurisdictions. As referenced above in Section (I)(B), the Tenth Circuit did not enact a new "perceived" standard, but articulated a standard previously accepted within the Tenth Circuit, as well as the other Circuit Courts of Appeals.

Pursuant to the division of power established by the Constitution, the legislature is to enact laws of general

application, and the courts are to decide particular cases arising under those laws, using the authority granted in them by the Constitution to "say what the law is" in particular cases. *Marbury v. Madison*, 5 U.S. 137, 177, 2 L. Ed. 60 (1803). Congress' role is to enact the law, and the courts' role is to interpret the law and apply the law in the cases within their jurisdiction. *Ruiz v. Scott*, 1996 WL 932104 (S.D. Tex. 1996).

In the instant case, the Tenth Circuit accurately interpreted and applied the EMTALA medical screening requirement, holding that a hospital's obligation under EMTALA is met when it treats patients perceived to have the same medical condition in the same manner. To hold otherwise would create a federal medical negligence statute, which is exactly what the Circuit Courts of Appeals have determined the Legislature wanted to avoid. The Tenth Circuit did not violate the separation of powers doctrine.

CONCLUSION

For the foregoing reasons, Respondent respectfully requests that this Honorable Court deny the Petition for a Writ of Certiorari. Petitioners have failed to show that the Tenth Circuit has entered a decision which is in conflict with other Courts of Appeals regarding the same matter, nor have Petitioners shown that the Tenth Circuit has so departed from accepted judicial proceedings so as to

warrant this Court's granting of the Petition, as articulated in Supreme Court Rule 10.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

CRYSTAL STAR PHILLIPS, individually, and as next of kin to Martin Shane Phillips, on behalf of THE ESTATE OF MARTIN SHANE PHILLIPS, by and through her mother, legal guardian and next friend, MINNIE CHRISTINA DACZEWITZ, and FRED MARTIN PHILLIPS, JR., parent of Martin Shane Phillips,	**Case No. 98.CV.829.H(E)**
Plaintiffs,	
vs.	
HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma, CAROLYN COBB, a physician, and TULSA EMERGENCY PHYSICIANS, INC., an Oklahoma corporation doing business in the State of Oklahoma,	
Defendants.	

AGREED PRE-TRIAL ORDER

IT IS ORDERED:

1. Statement of the case:

   a. Brief factual summary: On September 23, 1998, Martin Phillips, 25 years of age, presented to the

Emergency Room at Hillcrest Medical Center, was seen by Dr. Carolyn Cobb, Emergency Room Physician, and released. On September 28, 1998, Martin Phillips presented to a different hospital where he was evaluated as having bacterial endocarditis and died.

Prior Court Order: This Court issued an Order filed September 14, 1999, denying Hillcrest Medical Center's motion for summary judgment. This Court granted summary judgment in favor of Defendants Cobb and TEP as to the EMTALA claim only. This Court accepted supplemental jurisdiction over the state law claims pursuant to 28 U.S.C.A. § 1367(a).

b. Jurisdiction and Venue: Federal jurisdiction is based on Title 28 U.S.C.A. § 1331, pursuant to questions involving the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C.A. § 1395dd. Pursuant to 28 U.S.C. § 1391 (c), venue is proper in the Northern District, as a substantial part of the events or omissions, occurred in Oklahoma and the Northern District. Pursuant to prior Order, this Court is exercising supplemental jurisdiction pursuant to 28 U.S.C.A. § 1367. Defendants deny jurisdiction.

c. Plaintiffs' remaining contentions:

1. Plaintiffs allege this Court has federal question jurisdiction (this Court has accepted supplemental jurisdiction pursuant to 28 U.S.C.A. § 1367).

2. Plaintiffs allege that pursuant to Oklahoma's Wrongful Death Act, 12 O.S. § 1051, *et seq.*, Plaintiffs are entitled to prosecute this matter.

3. Defendant, Hillcrest Medical Center failed to provide an appropriate medical screening examination within the capabilities of their emergency department, which constitutes a violation of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. § 1395dd. Said failure was the proximate cause of the death of Martin Shane Phillips.

4. Plaintiffs allege Hillcrest Medical Center was negligent and that said negligence was the proximate cause of the death of Martin Shane Phillips.

5. Plaintiffs allege Hillcrest Medical Center is liable under the theory of ostensible agency.

6. Plaintiffs allege Hillcrest Medical Center is liable under the theory of respondeat superior.

7. Plaintiffs allege Carolyn Cobb, M.D., was negligent and that said negligence was the proximate cuase [sic] of the death of Martin Shane Phillips.

8. At all relevant times herein, Carolyn Cobb, M.D. was employed by Tulsa Emergency Physicians, Inc.

9. Plaintiffs allege Tulsa Emergency Physicians was negligent and that said negligence was the proximate cause of the death of Martin Shane Phillips.

10. Plaintiffs allege Tulsa Emergency Physicians is liable under the theory of respondeat superior.

11. Plaintiffs allege that as a consequence of the death of Martin Shane Phillips, Plaintiffs have suffered damages.

12. Martin Shane Phillips was neither contributorily nor comparatively negligent.

13. Plaintiffs allege Plaintiffs are entitled to actual and punitive damages.

d. Defendants' remaining contentions:

Defendant Carolyn Cobb's and Tulsa Emergency Physicians, Inc.'s

Defendant Carolyn Cobb, Tulsa Emergency Physicians, Inc.'s and Hillcrest Medical Center's contentions:

Defendant Cobb, and Tulsa Emergency Physicians, Inc. assert that based upon the patient's complaints, a complete, adequate, and thorough examination was carried out. Specifically, an appropriate medical screening examination was carried out as required under EMTALA. Also, Defendants Cobb and Tulsa Emergency Physicians, are not proper Defendants pursuant to EMTALA and relevant case law. These Defendants deny that Dr. Cobb's treatment fell below the standard of care relative to the patient's presenting complaints. These Defendants deny all allegations of negligence, improper diagnosis, or Plaintiff's entitlement to any alleged compensatory and punitive damages. Finally, Defendants state the patient was comparatively/contributorily negligent.

Defendant Hillcrest Medical Center's contentions:

1. Denial of all claims of the Plaintiffs.

2. Denial of federal court jurisdiction under EMTALA.

3. Denial of any violation of EMTALA and/or negligence.

4. Denial of agency for the physicians.

5. Denial of causation.

6. Denial of damages.

7. Contributory/comparative negligence of Martin Shane Phillips.

. . .

Jerry L. CUNNINGHAM, Heir-at-Law of Wanda June Cunningham, deceased, and Special Administrator of the Estate of Wanda June Cunningham, deceased, Plaintiff-Appellant,

v.

FREDONIA REGIONAL HOSPITAL; and Oswald C. Bacani, M.D., Defendants-Appellees.

No. 95-3350.

Oct. 11, 1996.

Before SEYMOUR, Chief Judge; PORFILIO and LUCERO, Circuit Judges.

ORDER AND JUDGMENT*

Appellant Jerry Cunningham, special administrator of the estate of his deceased wife, Wanda June Cunningham, brought suit against Fredonia Regional Hospital the Hospital [sic] and Dr. Oswald Bacani raising claims under both Kansas Medical malpractice law and the federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd(a)-(c). The district court granted the Hospital's summary judgment motion on the EMTALA claim and dismissed the pendent state law claim without prejudice. Mr. Cunningham now appeals the district court's judgment on the EMTALA claim. We affirm.

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* This order and judgment is not binding precedent, except under the doctrines of law of the case, res judicata, and collateral estoppel. This court generally disfavors the citation of orders and judgments; nevertheless, an order and judgment may be cited under the terms and conditions of 10th Cir. R. 36.3.

On October 7, 1992, Mrs. Cunningham visited Dr. Phillip Rindt, her family physician, complaining of chest pains, nausea, and shortness of breath. After examining Mrs. Cunningham, Dr. Rindt concluded her chest pains were not life-threatening and sent her home.

Upon returning home, Mrs. Cunningham continued to experience chest pains and became increasingly uncomfortable. That evening, unable to contact Dr. Rindt, Mr. Cunningham phoned Dr. Rindt's partner, Dr. Bacani. After listening to Mr. Cunningham describe his wife's visit to Dr. Rindt and her continued chest pains, Dr. Bacani said he would telephone the Hospital and Prescribe a pain shot for Mrs. Cunningham.

Dr. Bacani phoned the Hospital and gave his instructions for Mrs. Cunningham's pain shot. When Mrs. Cunningham and her husband arrived at the emergency room, Mrs. Cunningham was examined by Nurse Jewel Allen. Because she concluded Mrs. Cunningham was not suffering from an emergency medical condition, Nurse Allen gave the prescribed pain shot and sent Mrs. Cunningham home. Later that evening, Mrs. Cunningham died after suffering a heart attack during her sleep.

Under the EMTALA, also referred to as the Patient Anti-Dumping Act, a hospital must provide to all individuals arriving in the emergency room for examination and treatment "an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists." 42 U.S.C. § 1395dd(a). Accordingly, "a hospital violates section 1395dd(a) when

it does not follow its own standard [screening] procedures." *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir.1994).

In this case, Mr. Cunningham contends the district court should not have awarded summary judgment on the EMTALA claim because a question of fact existed on which Hospital screening procedure was applicable and whether the Hospital complied with the procedure. We review a grant of summary judgment de novo, applying the same standard as the district court. *Committee for the First Amendment v. Campbell*, 962 F.2d 1517, 1521 (10th Cir.1992). "Summary judgment is appropriate when there is no genuine dispute over a material fact and the moving party is entitled to judgment as a matter of law." *Russillo v. Scarborough*, 935 F.2d 1167, 1170 (10th Cir.1991). In reviewing the record, we consider the evidence in the light most favorable to the non-moving party. *Eaton v. Jarvis Prods. Corp.*, 965 F.2d 922, 925 (10th Cir.1992).

Mr. Cunningham asserts the Hospital, in this case, should have followed its "INITIAL E.R. CARE FOR PATIENT WITH CHEST PAIN" policy (Chest Pain Policy) which requires a physician to examine patients presenting with "life-threatening symptoms of chest pain." Mr. Cunningham argues the Chest Pain Policy was the applicable policy because his wife arrived in the emergency room complaining of chest pains. Therefore, Mr. Cunningham contends a physician, rather than a nurse, should have examined Mrs. Cunningham.

The Hospital, on the other hand, argues the relevant screening procedure is set out in the Hospital guideline entitled, "DETERMINATION OF VALID EMERGENCY

ILLNESS/INJURY." (Emergency Illness Policy). Under the Emergency Illness Policy, a physician is only required to examine an emergency room patient if the patient presents "with a valid emergency illness/injury." Otherwise, "patients with straight forward [sic], straight diagnosis, and treatment with low complexity with low possibility of morbidity can be evaluated by nursing personnel" if the nursing personnel are in verbal contact with a physician for such patients. In this case, because the nursing personnel had been in contact with Dr. Bacani, and had determined Mrs. Cunningham did not suffer from an emergency illness, the Hospital asserts no physician was required to examine Mrs. Cunningham.

After examining both policies, the district court determined the Hospital was required to follow the Emergency Illness Policy. The court explained, "[a]lthough the plaintiff here alleges that the hospital was required to follow the 'chest pain' policy, it is clear from the text of this policy that it does not apply in all cases of chest pain, but rather, applies only in cases of 'potential life-threatening symptoms of chest pain.' " The court then held there was no evidence the Hospital failed to comply with its standard screening procedure under the Emergency Illness Policy and thus the EMTALA claim failed.

Mr. Cunningham argues, first, Nurse Allen's deposition testimony indicates a dispute of material fact existed which hospital policy applied. However, after reviewing the record, we find Nurse Allen's testimony merely confirms, under the circumstances of this case, the Emergency Illness Policy was the applicable policy.

Nurse Allen testified had Mr. Cunningham arrived in the emergency room without orders from her physician, Nurse Allen would have followed the Chest Pain Policy. However, because Mrs. Cunningham had already been examined by her personal physician, had been in contact with Dr. Bacani, and had arrived at the Hospital with instructions from Dr. Bacani, Nurse Allen applied the Emergency Illness Policy rather than the Chest Pain Policy. Therefore, we find unpersuasive Mr. Cunningham's argument Nurse Allen's testimony created a disputed fact sufficient to overcome summary judgment.

Mr. Cunningham next argues summary judgment was inappropriate because the text of the Chest Pain Policy is ambiguous, and the district court should have allowed the introduction of extrinsic evidence to resolve the ambiguities. We disagree.

The stated purpose of the Chest Pain Policy is to "assess and support the patient with potential life-threatening symptoms of chest pain until the physician arrives." The policy therefore unambiguously states it applies to patients with "potential lifethreatening [sic] symptoms of chest pain." If, as Mr. Cunningham argues, the policy is meant to apply in all cases of chest pain, the "potential life-threatening symptoms" language is superfluous.

Moreover, Mr. Cunningham's interpretation of the Chest Pain Policy would require Hospital physicians to see all individuals complaining of any type of chest pain. Thus, an individual exhibiting symptoms of a fractured sternum, for example, would be entitled to an examination by a Hospital physician. We find no evidence the

Hospital Chest Pain Policy was intended to reach such non-emergency situations.

Rather, the record indicates it is the Emergency Illness Policy which sets out the screening procedure to determine whether an individual's illness is an emergency situation requiring an examination by a physician. Thus, if under the Emergency Illness Policy, a nurse determines an individual has "potentially life-threatening symptoms" of chest pain, then that individual must be seen by a physician. However, if, as here, the nurse determines the chest pains are not "potentially life-threatening," examination by a physician is unnecessary.

Mr. Cunningham's third argument also misses the mark. He contends the district court improperly resolved several disputed facts to conclude the Chest Pain Policy was inapplicable. In particular, Mr. Cunningham claims the court must have determined Mrs. Cunningham did not have "potential life-threatening symptoms" of chest pain and must have concluded she had a "low possibility of morbidity." However, to determine the policy was inapplicable, the district court merely had to determine the *Hospital* did not think Mrs. Cunningham had "potentially life-threatening symptoms" of chest pain or a high possibility of morbidity. Because Mr. Cunningham failed to present any evidence to the contrary, we cannot conclude the district court erred in resolving these issues in favor of the Hospital.

Mr. Cunningham next urges, even if the Hospital followed the appropriate screening policy, this court should hold the Hospital's policy inadequate as a matter of law. However, in *Repp*, 43 F.3d at 522 n. 4, we held "[a]

court should ask only whether the hospital adhered to its own procedures, not whether the procedures were adequate if followed." It is well-settled in this circuit that one panel of this court cannot overrule the decision of another panel. *United States v. Zapata*, 997 F.2d 751, 759 n. 6 (10th Cir.1993). Accordingly, we decline to address the adequacy of the Hospital policy.

In the alternative, Mr. Cunningham requests this case be remanded to allow further discovery which the district court denied. We review the district court's refusal to postpone ruling on summary judgment pending further discovery for an abuse of discretion. *See, e.g., Building and Constr. Dep't. v. Rockwell Int'l Corp.*, 7 F.3d 1487, 1496 (10th Cir.1993). The party requesting additional discovery must show how further discovery will permit rebuttal of the movant's arguments. *See, e.g., Jensen v. Redevelopment Agency of Sandy City*, 998 F.2d 1550, 1554 (10th Cir.1993). Based on the evidence in the record, Mr. Cunningham has not shown how additional discovery would indicate the Hospital failed to follow applicable screening procedures.

We conclude Mr. Cunningham has failed to state a claim under EMTALA because the evidence in the record indicates the Hospital followed its standard screening procedure and determined Mrs. Cunningham did not suffer from an emergency medical condition. This decision, however, leaves unaffected Mr. Cunningham's malpractice claim.

AFFIRMED.